COMMONWEALTH OF MASSACHUSETTS

SUPERIOR COURT
CIVIL ACTION
NO. 2012-00638

DAVID LEW, ADMINISTRATOR
OF THE ESTATE OF JASON LEW,
Plaintiff,

V.

MEREDITH GILSON, M.D.,
DENISE DALLACOSTA, R.N., AND
PMG PHYSICIAN ASSOCIATES, P.C.,
Defendants.

**PLAINTIFF'S SUPPLEMENT TO THE PRE-TRIAL MEMORANDUM**

**VI. EXPERT WITNESSES**

**A. Plaintiff's Expert Witnesses**

The following expert may be called to testify at the time of trial depending upon the scheduling of the trial by the court and the expert's availability. To the extent the expert listed below is unavailable to testify at the time of trial, the plaintiff expects to call to trial, as a substitute for any such expert, an expert who is expected to testify to the same opinions and on the same grounds.

**Ralph Freidin, M.D.**
**Consultations of Internal Medicine**
**25 Channel Center**
**Unit #1102**
**Boston, MA 02210**

Dr. Freidin may be expected to testify, specifically, but not limited thereto, as to the standard of care required by the defendants, their departure from that standard of care, the causal relationship between the defendants' negligence, gross negligence and Mr. Lew's injuries and death, and the nature, cause, extent, findings, diagnosis, prognosis, as well as his conscious pain and suffering as a result of the defendants' departure from the standard of care required of them.

Dr. Freidin may be expected to testify both generally and with specific reference to Mr. Lew's case regarding: post-surgical care following craniotomy including but not limited to the complications, treatment, prognosis, nursing care, therapies, and medications; Coumadin, its indications, contraindications, monitoring of patients on Coumadin in day to day life, pre-operatively and post operatively, its complications, risks and benefits; atrial fibrillation, its

causes, effects, treatments, diagnosis and prognosis; hypertension, its causes, effects, treatments, diagnosis and prognosis; chest pain, its causes, signs, symptoms, diagnosis, treatment, prognosis, the significance of chest pain in a patient such as Jason Lew; Pulmonary embolism/thromboembolism and its causes, signs, symptoms, diagnosis, treatment, prognosis and measures taken when there is a suspicion of embolism; Mr. Lew's conscious pain and suffering as well as his life expectancy based upon Dr. Freidin's education, training and experience, as well as the U.S. Life Tables; and the literature regarding these topics.

Dr. Freidin will testify that the defendants failed to inform Mr. Lew of the material risks of his condition and the risk associated with the defendants' proposed course of treatment, and failed to inform the plaintiff's decedent of the alternatives available to the defendants' proposed course of treatment. The plaintiff's decedent should have been informed of such risks and alternatives, if he had been informed of the appropriate information, he would not have consented to the defendants' proposed course of treatment.

The Plaintiff's expert will base his opinions on his education, training, skill, knowledge, experience and review of the relevant medical records and other documents provided to him in connection with this case.

The expert may be expected to testify to the following facts:

Mr. Lew worked as a mental health aide and had a past medical history significant for atrial fibrillation, hypertension, hyperlipidemia and malignancy (not specified). His atrial fibrillation was treated with Coumadin.

On 3/24/11, Mr. Lew was struck on the head by a patient. Near the end of his shift he became confused and then unresponsive. EMS was called, and he was transported to the Falmouth Hospital ER. Upon arrival to the hospital he was still unresponsive and was intubated. A head CT scan showed a large subdural hematoma with a midline shift. He was immediately transferred to Cape Cod Hospital (CCH) for care by a neurosurgeon.

Upon arrival to CCH, Mr. Lew was transported directly to the operating room for an emergency craniotomy to evacuate a large right-sided acute subdural hematoma. Because he had been taking Coumadin, an anticoagulant, for his atrial fibrillation, his coagulation had to be corrected before he went to the operating room. For this reason, he was given 5mg of Vitamin K and 2 units of fresh frozen plasma intravenously in the Cape Cod Hospital Emergency Room. During the procedure, he was found to have a large, right, acute, subdural hematoma with two cortical bleeders. The clot was evacuated and the bleeding stopped with bipolar diathermy. On 3/25/11, a post-operative pulmonary consult noted that Mr. Lew remained intubated and recommended that a tapering of sedation be followed by extubation if possible. He was placed in venodyne boots in an effort to reduce the risk of deep vein thrombosis and subsequent pulmonary embolism. Post-operatively, his blood pressure was monitored by the medical service.

By the morning of 3/29/11, Mr. Lew was breathing on his own and able to ambulate to the bathroom with a walker and had a steady gait. At this time he denied any chest pain or shortness of breath. Later on the 29th, the physical therapist recorded that Mr. Lew was

independent getting from supine position in bed to standing and that he was able to walk 150 feet twice with a rolling walker. It was also noted that his ability to walk had improved compared to 3/27/11. When check by the nurse at 9:20 PM on 3/29/11, he no longer had any pain in his knee. On 3/30/11, he continued to deny any pain, was alert and awake, and his incision was clean, dry and intact. The plan was to discharge him to home with VNA services.

On 3/30/11 Mr. Lew was discharged home. He was to start physical rehabilitation at home as part of the VNA services the following day. A neurosurgical discharge referral was completed on 3/28/11. It noted that Mr. Lew's discharge diagnosis was head trauma/SDH. It noted that Mr. Lew was not on Coumadin and was to follow up with Dr. Gilson. The referral included the 10 medications he was prescribed when he left the hospital. A nursing – patient care referral was completed on 3/30/11 and faxed to the VNA. The diagnoses listed on the nursing referral were 1) right acute subdural hematoma with mass effect/midline shift; 2) respiratory failure; and 3) knee pain. The referral also noted that Mr. Lew was independent in all of his activities with the assistance of his rolling walker.

On 3/31/11, Mr. Lew had his first visit. The VNA Referral-Clinical listed his medical problems as 1) traumatic subdural hematoma; 2) aftercare injury/trauma; 3) atrial fibrillation; and 4) hypertension. The reason given for the services was status post subdural hematoma, craniotomy, aftercare. It was noted that Mr. Lew was discharged home with a walker. He was having moderate pain (4/10) in his 'anterior head'. He had no shortness of breath. The exam of his thorax was normal. He was noted to be weak, deconditioned; only walking occasionally and required assistance with activities of daily living. He was to have visits from a skilled nurse one to two times a week for nine weeks.

On 4/4/11, visiting nurse, Denise DallaCosta, RN, visited Mr. Lew at home. Nurse DallaCosta arrived at 1:15 p.m. and left at 1:45 p.m. Nurse DallaCosta noted that Mr. Lew complained of mild (3/10) achiness to his right knee that radiated throughout the knee. She also indicated that Mr. Lew was concerned about moderately severe (6/10) left sided chest pain. This pain had not been recorded previously. Mr. Lew described it as stabbing at times, increasing with position change and deep inspiration, and was uncontrollable. He was unable to tolerate sustained activity greater than 2-5 minutes without having to rest because of fatigue and pain. He declined to ambulate during this visit. At rest he had no shortness of breath and his oxygen saturation was 98%. The pain was so severe that it woke him up at night and affected his mobility. Nurse DallaCosta noted one of her primary concerns to be pulmonary embolism. She suggested warm packs and pain medication, and instructed Mr. Lew to call 911 if the pain or shortness of breath increased or he became lightheaded. Nurse DallaCosta called Mr. Lew's primary care physician, Meredith Gilson, M.D. to inform her of Mr. Lew's new symptoms. Nurse DallaCosta was told Dr. Gilson would call Mr. Lew to schedule an appointment. Mr. Lew was instructed to follow up on his doctor appointment.

On 4/5/11 at 12:30 p.m., an occupational therapist from the VNA, arrived at Mr. Lew's house. She noted that Mr. Lew appeared to be having difficulty attending to conversation and was nodding off. He had 10/10 sharp left chest pain that occurred when standing, lying down and with a deep breath. Mr. Lew had shortness of breath with inhalation. The occupational therapist called Dr. Gilson's office and spoke to a nurse to tell her that she was sending Mr. Lew

to the emergency room. There is no indication in Dr. Gilson's records that she planned to evaluate the patient at any time or advised Mr. Lew to seek treatment at an emergency room. A voicemail was left for Nurse DallaCosta to notify her of the situation. On 4/5/11, Mr. Lew was discharged from the VNA due to his hospitalization for pulmonary embolus.

Upon Mr. Lew's arrival to the Falmouth Hospital ER, he was noted to have difficulty breathing, increased shortness of breath, and continuous left chest pain. The onset of his symptoms was reported as being gradual over the course of three days but suddenly worse on 4/511. He was tachycardic, hypotensive and tachypneic. His oxygen saturation measured 0 upon arrival to the emergency room. CT scan with and without contrast showed a large 'saddle embolus' (straddling the bifurcation of the main pulmonary artery) with extensive peripheral pulmonary emboli and right heart strain resulting from the extent of 'clot burden'. He was intubated and transferred to Brigham and Women's Hospital (BWH) for specialized care to remove the embolus blocking blood flow to Mr. Lew's lungs.

On the way to the BWH ER, Mr. Lew had labile blood pressures and was given norepinephrine. Upon his arrival at BWH he suffered a cardiac arrest. Cardiac surgery was notified and arrangements were made for an emergent surgical thrombectomy. Mr. Lew underwent a salvage surgical pulmonary embolectomy. He tolerated the procedure reasonably well but remained critical on the basis of his pre-operative presentation.

On 4/6/11, at 3:53 p.m., Nurse DallaCosta made a phone call to Mr. Lew's fiancé regarding his emergency room evaluation. The same day Nurse DallaCosta made an addendum to her original note from the previous day and that Mr. Lew had declined an emergency room evaluation at the time of her visit.

On post-operative day one, Mr. Lew required high pressor and inotropic support and nitric oxide ventilation. He was subsequently weaned off nitric oxide. On post-operative day two he received 7 units of fresh frozen plasma for INR reversal. He was subsequently re-started on a heparin drip due to his pulmonary embolus. He continued to require significant pressors and intravenous fluid resuscitation due to labile blood pressures. On post-operative day three, Mr. Lew was made DNR/DNI. On post-operative day four, due to increasing pressor requirements, continued evidence of renal and liver failure and overall poor prognosis, the family elected to make Mr. Lew comfort measures only.

Mr. Lew died on 4/8/11 at 2:40 p.m. from acute pulmonary thromboembolism.

Dr. Freidin may be expected to testify that pulmonary embolism is a blockage of the main artery of the lung or one of its branches by a substance that has travelled from elsewhere in the body through the bloodstream (embolism). Pulmonary embolism most commonly results from deep vein thrombosis (a blood clot in the deep veins of the legs or pelvis) that breaks off and migrates to the lung. The deep vein thrombosis may cause leg and/or knee pain. Physical findings in patients with deep vein thrombosis may be minimal swelling and/or tenderness in the mid-portion of the calf. Because of reduced mobility, patients are at a heightened risk of developing deep vein thrombosis, and thus pulmonary embolism, for at least five weeks following surgery. When blood flow through the lungs is obstructed, it cannot be oxygenated.

This results in shortness of breath. Patients may experience this as breathlessness or fatigue with activity or even at rest. If an embolus is small enough to reach to the periphery of the lung it can cause exquisite pain because it lodges near the innervation of the pleural nerves. This then results in chest pain (pleurisy - inflammation of the tissue lining the lung) that worsens with breathing. Peripheral pulmonary emboli are more apt to result in pleuritic chest pain although it may also be a symptom of larger more central emboli.

Treatment for pulmonary embolism includes anticoagulation therapy, and surgical intervention such as pulmonary embolectomy. If left untreated, a pulmonary embolism can lead to death.

- Dr. Freidin may be expected to testify that for these reasons, the accepted standard of care in Massachusetts from 2011 to the present has required the average qualified registered nurse to: 1) recognize and appreciate the risk of pulmonary embolism to a patient eleven days post operatively; 2) recognize and appreciate that when a patient, eleven days post-operative, develops chest pain that increases with breathing and also has knee pain it is highly likely that the patient has developed pulmonary emboli; 3) recognize and appreciate that pulmonary emboli can be life threatening; 4) recognize and appreciate that when pulmonary embolus is considered in a differential diagnosis, it must be acted upon as an emergency and the patient must be sent to an emergency room where the patient will have emergency imaging to know if a pulmonary embolism is present; 5) notify the patient that pulmonary embolism is a life threatening condition; and 6) document, at the time of the visit, if the patient was instructed to go to an emergency room.

In Dr. Freidin's professional opinion, to a reasonable degree of medical certainty, the care and treatment rendered to Jason Lew by Denise DallaCosta, R.N. on 4/4/11 fell below the accepted standard of care at the time for the average qualified registered nurse when Nurse DallaCosta failed to: 1) recognize and appreciate the risk of pulmonary embolism to a patient eleven days post operatively; 2) recognize and appreciate that when a patient, eleven days post-operative, develops chest pain that increases with breathing and also has knee pain it is highly likely that the patient has developed pulmonary emboli; 3) recognize and appreciate that pulmonary emboli can be life threatening; 4) recognize and appreciate that when pulmonary embolus is considered in a differential diagnosis, it must be acted upon as an emergency and the patient must be sent to an emergency room where the patient will have emergency imaging to know if a pulmonary embolism is present; 5) notify the patient that pulmonary embolism is a life threatening condition; and 6) document, at the time of the visit, if the patient was instructed to go to an emergency room.

In Dr. Freidin's professional opinion, to a reasonable degree of medical certainty as a direct result of Nurse DallaCosta's failure to comply with the accepted standard of care, as outlined above, Mr. Lew suffered a premature and preventable death due to cardiac arrest from pulmonary thromboembolism. Had Nurse DallaCosta rendered care in accordance with the accepted standard of care, as outlined above, Mr. Lew would have been admitted to the hospital on 4/4/11, would have been treated with anticoagulation therapy, and if needed had surgical intervention prior to suffering a cardiac arrest, and more likely than not would not have suffered a premature and preventable death.

Dr. Freidin may be expected to testify that the accepted standard of care in Massachusetts from 2011 to the present has required the average qualified family medicine physician to: 1) recognize and appreciate the risk of pulmonary embolism to a patient eleven days post operatively; 2) recognize and appreciate that when a patient, eleven days post-operative, develops chest pain that increases with breathing and also has knee pain it is highly likely that the patient has developed pulmonary emboli; 3) recognize and appreciate that pulmonary emboli can be life threatening; 4) recognize and appreciate that when pulmonary embolus is considered in a differential diagnosis, it must be acted upon as an emergency and the patient must be sent to an emergency room where the patient will have emergency imaging to know if a pulmonary embolism is present; 5) notify the patient that pulmonary embolism is a life threatening condition; and 6) document if the patient was instructed to go to an emergency room.

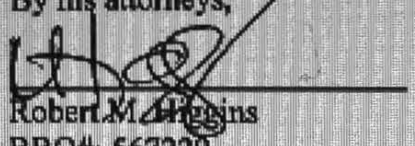
In Dr. Freidin's professional opinion, to a reasonable degree of medical certainty, to a reasonable degree of medical certainty, the care and treatment rendered to Jason Lew by Meredith Gilson, M.D. on 4/4/11 fell below the accepted standard of care at the time for the average qualified family medicine physician when Dr. Gilson failed to: 1) recognize and appreciate the risk of pulmonary embolism to a patient eleven days post operatively; 2) recognize and appreciate that when a patient, eleven days post-operative, develops chest pain that increases with breathing and also has knee pain it is highly likely that the patient has developed pulmonary emboli; 3) recognize and appreciate that pulmonary emboli can be life threatening; 4) recognize and appreciate that when pulmonary embolus is considered in a differential diagnosis, it must be acted upon as an emergency and the patient must be sent to an emergency room where the patient will have emergency imaging to know if a pulmonary embolism is present; 5) notify the patient that pulmonary embolism is a life threatening condition; and 6) document if the patient was instructed to go to an emergency room.

In Dr. Freidin's professional opinion, to a reasonable degree of medical certainty as a direct result of Dr. Gilson's failure to comply with the accepted standard of care, as outlined above, Mr. Lew suffered a premature and preventable death due to cardiac arrest from pulmonary thromboembolism. Had Dr. Gilson rendered care in accordance with the accepted standard of care, as outlined above, Mr. Lew would have been admitted to the hospital on 4/4/11, would have been treated with anticoagulation therapy, and if needed had surgical intervention prior to suffering a cardiac arrest, and more likely than not would not have suffered a premature and preventable death.

The expert will also rebut the anticipated expert testimony of the defendants.

Plaintiff reserves the right to supplement this disclosure prior to trial.

Respectfully submitted,
The plaintiff,
By his attorneys,



Robert M. Higgins
BBO#: 567229
Barrie S. Duchesneau
BBO#: 673794
LUBIN & MEYER, P.C.
100 City Hall Plaza
Boston, MA 02108
(617) 720-4447

COMMONWEALTH OF MASSACHUSETTS

BARNSTABLE, SS.

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**Expert Witness Certification**

I, Ralph Freidin, M.D., have been retained as an expert witness by the Plaintiff in the above referenced matter. I have reviewed the expert disclosure as set forth within the Plaintiff's Supplement to the Pre-Trial Memorandum. I hereby certify that I will testify consistent with the disclosure contained in said document as it applies to me and that it accurately states the subject matter(s), the substance of the facts and opinions, and a summary of the grounds for the opinion(s), to which I expect to testify at the trial of this case.

R Freidin MD

Ralph Freidin, M.D.